MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07086

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery Co., Bethesda, Md.
City or town: 4632 Windsor Lane
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred:
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4632 Windsor Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elsie R. Aird

3.(b) Social Security Number: No #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 30, 1890

8. AGE: Years: 55 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Retired U.S. Govt.

11. Industry or business:

FATHER — 12. Name: John C. Aird; 13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Margaret Meveigh; 15. Birthplace: N.Y.

16. Informant: Clara Aird
Address: 4632 Windsor Lane, Bethesda, Md

17. removal (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)
Cemetery or crematory:
Location: Syracuse, N.Y.

18. Funeral director: The D.W. Dines Co.
Address: 2901 14th St.N.W., Wash, D.C.

19. 7/6 19 45 Mrs E Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1945 at 12 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940 to July 6 1945
and that I last saw her alive on July 5 1945

Immediate cause of death	DURATION
Cardiac failure	5 hrs.
Due to: Pneumonia	1 mo.
Due to: Carcinomatosis from Cancer of Pt. Breast	10 mo.
Other conditions	14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Mx-carcinoma Rt breast
Date of op. 1930
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E.H. Hershenbark M. D. or other
Address: 1007-L St. NW Date signed: 7/6/45

Deceased in Md. Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ 07087

Reg. Dist. No. 217

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Inc

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Brinklow
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Anna Awkward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married.

8.(b) Name of husband or wife: Robert Awkward.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 20, 1871

8. AGE: Years	Months	Days	If less than one day
73	6	2	..... hrs. ..... min.

9. Birthplace: Montgomery Co. Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: John Hill

13. Birthplace: Sandy Spring, Md.

MOTHER 14. Maiden name: Martha Holland

15. Birthplace: Highland, Md.

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1945 (month) (day) (year)

Cemetery or crematory: Sandy Spring

Location: Sandy Spring, Md.

18. Funeral director: R. L. Snowden

Address: 246 N. Washington St. Rockville Md.

19. July 23 1945 (Date rec'd by registrar) Gertrude B. Fawcett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1945 at 7 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 6 1945 to July 22 1945
and that I last saw h.e.r. alive on July 22 1945

Immediate cause of death	DURATION
Anaemia	3 day
Due to: Chronic Interstitial nephritis & hypertension	4 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md Date signed 7/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07088

★ Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Brinklaw

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bacon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 10, 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 30 min.

9. Birthplace Olney, Montgomery Co., Maryland (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Charles Thomas Bacon

13. Birthplace Olney, Maryland.

MOTHER 14. Maiden name Mary Elizabeth Powell

15. Birthplace Daisy, Maryland.

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1945 (month) (day) (year)

Cemetery or crematory Sandy Spring

Location Sandy Spring Md

18. Funeral director Robert L. Snowden

Address Rockville, Md

19. 7-12 1945 (Date rec'd by registrar) Gertrude B. Lawton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945, to July 10 1945 and that I last saw him alive on July 10 1945

	DURATION
Immediate cause of death Prematurity	
Due to 5 mos.	
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring Md Date signed 7/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

07089

Reg. Dist. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daniel Brady Barnes

3.(b) Social Security Number: 214-12-7975

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lucy Barnes

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): 4-9-[illegible]

8. AGE: Years	Months	Days	If less than one day
69, 1875	9	18	...hrs. ...min.

9. Birthplace: Martinsburg Md. (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER — 12. Name: Alexander Barnes.

FATHER — 13. Birthplace: Martinsburg Md.

MOTHER — 14. Maiden name: Henrietta Sharid

MOTHER — 15. Birthplace: Martinsburg Md.

16. Informant: Mrs Lucy Graham.

Address: Dickerson Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8. 45 (month) (day) (year)

Cemetery or crematory: Poolesville Md.

Location: Poolesville Md.

18. Funeral director: Clarence H Davis

Address: Poolesville Md

19. July 8 1945 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945, at 5:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1944 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	12 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J Bronchart M D

M. D. or other

Address: Gaithersburg Md Date signed 7-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

07690

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
XXXXXXXXX Hospital, institution, or street address where death occurred:
1110 Flower Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1110 Flower Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war X

3. (a) FULL NAME PHYLISS MAE BARTLETT

3. (b) Social Security Number X

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife X
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) May 14th. 1945

8. AGE:	Years	Months	Days	If less than one day
	0	1	17	...... hrs. ...... min.

9. Birthplace Takoma Park, Md.
(Town, county, and state)
10. Usual occupation X
11. Industry or business X

FATHER
12. Name Edmon Bartlett
13. Birthplace Kentucky

MOTHER
14. Maiden name Mary Seek
15. Birthplace Takoma Park, Md.

16. Informant Mrs. Edmon Bartlett (mother)
Address 1110 Flower Ave. Takoma Pk.

17. Burial Date thereof 7/2/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Colesville
Location Colesville, Mont. Co. Md.

18. Funeral director Warner E. Pumphrey
Address 8434 Ga. Ave. Silver Spring, Md.

19. July 2 1945 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam case 19.... to .... 19....
and that I last saw h.... alive on .... 19....

Immediate cause of death	DURATION
Congenital heart disease	Dep. Med. Exam.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE Frank J. Broschart M.D.
Dep. Med. Exam.
M. D. or other
Address Gaithersburg Md Date signed 7-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07691

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Nebr. County:

City or town: N. Platte
(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 S Willow St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BAYLES, Paul Adair, PhM3c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Mary ElizabethBayles

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 15 April 1912

8. AGE: Years	Months	Days	If less than one day
33	2	28	hrs. min.

9. Birthplace: Nebr.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Wife: Mrs. Mary Elizabeth Bayles
Address: 601 S. Willow St., N. Platte, Nebr.

17. removal (Burial, cremation, or removal. Which?) Date thereof 7-16-45 (month) (day) (year)

Cemetery or crematory:

Location: N. Platte, Nebraska JCT

18. Funeral director: Geo. W. Wise, Undertaker
Address: 2900 M St., N. W., Wash., D.C.

19. 7-14 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 July 19 45 at 1:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 19 45 to 13 July 19 45 and that I last saw h... in ...alive on 13 July 19 45

	DURATION
Immediate cause of death: Respiratory Failure	
Due to: Cystic glioma of the cerebellum	5 mo's.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Cystic glioma of cerebellum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. B. Grainger
H. B. GRAINGER, Lt. (MC) USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 7-13-45

Evidence for change of year of birth of deceased is shown on FILM No. G 97 JUL 27 1945

4601 Leland St C C

67092

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Silver Springs
Hospital, institution, or street address where death occurred: Suburban Hospital 8600 Old Georgetown Rd.
How long in hospital or institution? 18 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. GRUBB ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war NONE

3.(a) FULL NAME Thomas Bayne

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	

6.(b) Name of husband or wife Margaret C. Bayne
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC-8TH 1877 1876

8. AGE: Years	Months	Days	If less than one day
68	7	3	..... hrs. ..... min.

9. Birthplace IRELAND (Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business DAIRYMAN.
FATHER 12. Name THOMAS BAYNE.
13. Birthplace IRELAND
MOTHER 14. Maiden name MARGARET FLAHERTY
15. Birthplace IRELAND
16. Informant MRS MARGARET C BAYNE
Address GRUBB RD SILVER SPRING - MD
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JULY 14 - 1945 (month) (day) (year)
Cemetery or crematory ST MARY'S
Location ROCKVILLE MONTG CO. MD
18. Funeral director Danner & Pumphrey
Address 8636 Ga Ave Silver Spring. Md
19. July 19 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/45 19..... at 12'15 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/4 1945 to 7/11 1945
and that I last saw h... alive on 7/11/45 1945

Immediate cause of death	DURATION
Congestive Heart failure	
Due to Hypostatic pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J L Marks M.D.
M. D. or other
Address 4601 Leland St. Date signed 7/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07093

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days.
Hospital, Institution, or street address where death occurred:
Suburban Hospital.
How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Arkansas. County Pulaski
City or town Little Rock.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1218 West 21st St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Madara Bentley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	Widowed.

6.(b) Name of husband or wife John Bentley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1899.

8. AGE: Years	Months	Days	If less than one day
46	0	13	..... hrs. ..... min.

9. Birthplace Memphis, Tenn
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Clapton
13. Birthplace
14. Maiden name
15. Birthplace

16. Informant Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)
Cemetery or crematory
Location Little Rock Ark

18. Funeral director H. F. Wilson - 1337 25th N.W.
Address Little Rock Ark Wash D.C.

19. 7/21 (Date rec'd by registrar) 19 45 Mrs E Jones Registrar
7/21/45

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 19 45 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 19 45 to July 20 19 45 and that I last saw her alive on July 20 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis & infarction brain.	3 days.
Due to Arteriosclerotic disease	Several years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Confirmation of above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Edward J Hughes M. D.
1726 Eye St NW
Address Washington 6 D.C. Date signed 7/20/45

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-D

CERTIFICATE OF DEATH

07094

Reg. Dist. No. 216

Form G97 AUG 17 1945

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital Bethesda

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

Clifton Allen Bowie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married Single ✓

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25 1903

8. AGE: Years	Months	Days	If less than one day
41 +2			hrs. min.

9. Birthplace Montgomery Wheaton Maryland (Town, county, and state)

10. Usual occupation Sanitary Commission

11. Industry or business

FATHER 12. Name Claggett Bowie

13. Birthplace Howard County, Maryland

MOTHER 14. Maiden name Rosetta Murphy

15. Birthplace Howard County, Maryland

16. Informant Mother and Sister

Address Kensington, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/28/45 (month) (day) (year)

Cemetery or crematory

Location Washington

18. Funeral director W. Ernest Jarvis

Address 1432 U St. N.W. Wash. D.C.

19. 7/28 1945 Mrs E Jobes Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1945 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/24 1945 to 7/28 1945 and that I last saw h... alive on 7/28 1945

Immediate cause of death	DURATION
Ruptured aneurysm of aorta	1 hr.
Due to Aortitis (Probably luetic in origin)	several years
Due to Eagle was negative	
Other conditions Uremia	1 wk.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward A. Hines Jr. Washington 6 M. D. or other

Address 1726 Eye St. N.W. Date signed 9/28/49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

CERTIFICATE OF DEATH ★

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mons. & 13 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 mons. & 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Georgetown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1437 44th St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BREWSTER, David Lukens Shoemaker, Brig.Gen.USMC

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Marcer T. Brewster

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 31 Dec. 1887

8. AGE: Years	Months	Days	If less than one day
57	7	9	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: Robert J. N. Brewster
13. Birthplace: (deceased)

MOTHER
14. Maiden name: Leila Shoemaker
15. Birthplace: Washington, D. C.

16. Informant: wife: Mrs. Marcer T. Brewster
Address: 1437 44th St., Georgetown, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 7-12-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Geo. W. Wise 8C7

Address: 2900 M St., N. W., Wash., D.C.

19. 7-11 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 July 19 45, at 1240 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Dec 1944, to 10 July 1945, and that I last saw him alive on 10 July 1945.

Immediate cause of death	DURATION
Rupture abdominal Aneurysm	2
Due to: Arteriosclerosis	
Due to:	
Other conditions: multiple Myeloma, Anemia, Diabetes	3

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John C Boudreau, M. D. or other

Address: USTH. Bethesda Date signed: 10/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

07096

FILM No G 97 AUG 31 1945

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 47 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Richmond
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5814 Grove Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BRIGGS, William Carroll, AMM3c V-6 SV USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Mary A. Briggs

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12 May 1911

8. AGE: Years	Months	Days	If less than one day
34 ~~26~~	2	10	..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Joseph A. Briggs
13. Birthplace: Va. (deceased)

MOTHER
14. Maiden name: Mary E. Carroll
15. Birthplace: Va. (deceased)

16. Informant: wife: Mrs. Mary A. Briggs

Address: 5814 Grove Avenue, Richmond, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 7-22-45 (month) (day) (year)

Cemetery or crematory: Mt. Calvery

Location: Richmond, Va.

18. Funeral director: Geo. W. Wise J.C.F.

Address: 2900 M St., N. W., Wash., D. C.

19. 7-22 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 July 19 45 at 1025a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 June 19 45, to 22 July 19 45

and that I last saw him alive on 22 July 19 45

Immediate cause of death	DURATION
Respiratory Failure	
Due to Intra-Cranial Aneurysm	6-17 mo
Due to Circle of Willis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Large aneurysm circle of Willis Date of op. 7-22-45.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. A. SHELMAN Lt. (jg) (MC) USNR
M. D. or other

Address: US NH Bethesda, Md. Date signed: 7-22-45

VS A15 ch 12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-c)

CERTIFICATE OF DEATH

07097

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7hr

Hospital, institution, or street address where death occurred: Washington Sanitarium Hospital

How long in hospital or institution? 7hr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County: Montgomery

City or town: Washington - D.C. Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 62

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Brown, Sr. Henry B.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Minnie Lee Brown

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Mar. 31 1886

8. AGE: Years	Months	Days	If less than one day
59	3	4	____ hrs. ____ min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Brick Mason

11. Industry or business:

FATHER — 12. Name: ____ 13. Birthplace: Unknown

MOTHER — 14. Maiden name: ____ 15. Birthplace: Unknown

16. Informant: ____ Address: ____

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 7-5-45 (month) (day) (year)

Cemetery or crematory: ____

Location: Washington, D.C.

18. Funeral director: Huntimans Funeral Home

Address: 5932 Ga Ave N W

19. July 5 1945 (Date rec'd by registrar) J. W. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-5 1945 at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Fracture of skull and Internal hæmorrhage	Instantaneous
Due to: Rupture of Liver	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 7-4-45

Where did injury occur? Montgomery (City or town) Maryland (County) (State)

Injured at home, farm, industry, public place (where?): Highway or Street

Means of injury: Automobile Injured at work? No

23. SIGNATURE: Robert A. Hare M.D. or duly J. W. Bird M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 7/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

07698

CERTIFICATE OF DEATH

★ Reg. Diat. No. 213.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montg.
City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs.
Hospital, Institution, or street address where death occurred:
R.F.D. # 4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 4 Rockville, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Edward Butt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

B.(b) Name of husband or wife Betty Botts
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 23, 1877

8. AGE: Years	Months	Days	If less than one day
68	2	14	hrs. min.

9. Birthplace Derwood, Md.
(Town, county, and state)
10. Usual occupation Retired Govt Employee
11. Industry or business

FATHER
12. Name Robert McKinley Butt
13. Birthplace Md.

MOTHER
14. Maiden name Rebecca Riketts
15. Birthplace Md.

16. Informant Maurice Butt
Address Brather

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/10/45 (month) (day) (year)
Cemetery or crematory Derwood Cem.
Location Derwood, Md.

18. Funeral director Wm Reuben Dunphrey
Address 7557 Wis. Ave. Bethesda

19. 7/9/45 (Date rec'd by registrar) Josephine D. Hatton, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 7:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1945, to July 7 1945, and that I last saw him alive on July 6 1945

Immediate cause of death Cerebral apoplexy — DURATION 7 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. P. Hartley, M.D. M. D. or other
Address Rockville, Md. Date signed 7/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

07699

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months 23 days

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 8 months 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County: Jackson

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Morton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Evan (n) CHILDERS, MM3c USN Active

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 14, 1920

8. AGE:	Years	Months	Days	If less than one day
	25	5	21	hrs. min.

9. Birthplace: Ohio
(Town, county, and atate)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Lesker Childers
13. Birthplace: Ohio

MOTHER
14. Maiden name: Martha Tilley
15. Birthplace: Ohio

16. Informant: Father: Lesker Childers
Address: 32 Morton Street, Jackson, Ohio

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 6 July 1945 (month) (day) (year)

Cemetery or crematory:

Location: Jackson, Ohio

18. Funeral director: George W. Wise, Co. Inc. F.F.F.
Address: 2900 M St.N.W., Washington, D. C.

19. July 6 1945 (Date rec'd by Registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 July 1945, at 0037 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Oct. 1944, to 5 July 1945 and that I last saw h.. alive on 4 July 1945

Immediate cause of death	DURATION
Bronchiectasis	3½ yrs
Due to Post-operative death following lobectomy 15 hrs later. Delayed shock.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Bronchiectasis Right middle lower, left lower. Date of op. 20 Dec 1944, 4 July 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward M. Kent M. D. or other

Address: USNH Bethesda Md. Date signed: 5 July 45

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39-2a)

FILM No. G 97 AUG 6 1945

CERTIFICATE OF DEATH

07100

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mo. 14 days

Hospital, institution, or street address where death occurred: The Washington Sanitarium and Hospital

How long in hospital or institution? 11 mo 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 623 South Highland St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME William Athey Coates

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs. Ruth M. Coates

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1879

8. AGE: Years	Months	Days	If less than one day
65	66	10	11 ..... hrs. ..... min.

9. Birthplace: Waterford, Virginia (Town, county, and state)

10. Usual occupation: Store Keeper and Postmaster

11. Industry or business: General Store and Post Office

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Mary Athey Coates

MOTHER 15. Birthplace: Leesburg, Va.

16. Informant: Admission Record

Address: The Washington Sanitarium and Hospital

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/28/45 (month) (day) (year)

Cemetery or crematory:

Location: Arlington, Va.

18. Funeral director: C. J. Ives

Address: 2847 Wilson Blvd. Arlington, Va.

19. 7/28/45 (Date rec'd by registrar) Wilson Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19~~44~~45, at 11:23a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1944, to July 28 1945 and that I last saw him alive on July 28 1945

Immediate cause of death	DURATION
Congestive Cardiac Failure	two wks
Due to Arteriosclerosis	?
Due to	
Other conditions Pyelitis	three wks.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert A Hare M.D.

*M. D. or other

Address: Takoma Park, Md. Date signed 7/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

07101

★ Reg. Dist. No. 214

1. PLACE OF DEATH:
County MONTGOMERY
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or~~ street address where death occurred:
490 EASLEY ST
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMERY
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. 490 EASLEY ST
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MERRITT M. COBURN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of ~~husband or~~ wife CHRISTINA K.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB - 27 - 1876

8. AGE: Years	Months	Days	If less than one day
69	4	20	..... hrs. ..... min.

9. Birthplace AUGUSTA - KY.
(Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business

FATHER
12. Name CLAY C COBURN
13. Birthplace AUGUSTA - KY

MOTHER
14. Maiden name RHEA EMERSON
15. Birthplace OHIO

16. Informant MRS JAS L DAVIS - DAUGHTER
Address 490 EASLEY ST

17. BORIAL Date thereof 7 - 19 - 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location AUGUSTA, BRACKEN CO - KY
18. Funeral director Warner E Pumphrey
Address 8034 - Ga Ave. Silver Spring Md

19. July 19 18 45 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-45 19..... at 5 05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-4 19 45, to 7-17 19 45 and that I last saw h... alive on 7-16-45 19.....

Immediate cause of death	DURATION
(a) Coronary Thrombosis	48 Hrs
Due to (b) Arteriosclerotic Heart Disease Senility	10 yrs.
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Kenneth Slaughter M.D.
M. D. or other
Address 8252 Ga Ave Date signed 7-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-C)

CERTIFICATE OF DEATH

07102

Reg. Dist. No. 211

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH:

County: Montgomery

City or town: Monrovia R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:
Locust Hill Farm

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Monrovia R.F.D. #1,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Locust Hill Farm
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Vivian G. Smith Comer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph H. Comer, Jr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 27 1919

8. AGE: Years 25 | Months 9 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace: Wash. DC
(Town, county, and state)

10. Usual occupation: school teacher

11. Industry or business

FATHER 12. Name: Walter A. Smith

13. Birthplace: N.C.

MOTHER 14. Maiden name: Mattie Sue Robertson

15. Birthplace: N.C.

16. Informant: Mrs. Lawrence E. Ensor

Address: 2005 Lansdowne Way Silver Spring Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 4 1945 (month) (day) (year)

Cemetery or crematory: Washington Mem. D.C.

Location: Arlington Mem.

18. Funeral director: Joseph F. Burch's Sons

Address: 3034 M St. Nash. D.C.

19. July 4 1945 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1945; at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Bullet wound Thru at temple into brain	died instantly
Due to: (Suicide)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 7-4-45

Where did injury occur? Monrovia R.F.D. (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
M. D. or other

Address: Dep. Med. Exam. Montgomery Co. Md. Date signed: 7-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

07103

★ Reg. Dist. No. 247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Edmon

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) No

Stay in this community (yrs., or mos., or days) 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Washington D C Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 618 Irving ave N W

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Joseph D. Lancy

3. (b) Social Security Number has one but cant find it

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	White	Widowed

6 (b) Name of husband or wife Lottie

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 73 ! | Months | Days | If less than one day hrs. min.

9. Birthplace Washington D C

(Town, county, and state)

10. Usual occupation Bar - tender

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Mary Driscoll

15. Birthplace Ireland

16. Informant Mrs Ellen Rumold

Address Edmon, Maryland

17. Removal Date thereof July 1, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive

Location Washington D C

18. Funeral director H. J. Saltzman

Address 436-7th St S.W. Wash D C

19. July 1 1945 Gertrude B. Lawler

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 1 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1945, to July 1 1945 and that I last saw h- alive on June 30 1945.

Immediate cause of death, acute myocarditis with chronic nephritis — DURATION 4 days 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E Stumbleson M. D.

Address Sandy Spring Md Date signed 7/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24

07104

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1-2 days

Hospital, Institution, or street address where death occurred:
U.S.N.H., Bethesda, Maryland

How long in hospital or institution? 1 1-2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1414 Duke Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: DENITTO, Elizabeth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W-US	married

6.(b) Name of husband or wife: Leonard Denitto, CWT USN

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1919

8. AGE: Years	Months	Days	If less than one day
26	1	25	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: William I. Nugent
13. Birthplace: Va.

MOTHER
14. Maiden name: Elizabeth M. Scalon
15. Birthplace: Va.

16. Informant: Mother: Mrs. Elizabeth Nugent
Address: 1414 Duke St., Alexandria, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1 July 1945 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Alexandria, Va.

18. Funeral director: Hattie E. Fitzgerald
Fitzgerald Funeral Home
Address: 3245 Wilson Blvd., Arlington, Va.

19. July 1 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 July 1945 at 3:20A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1945, to July 1 1945 and that I last saw her alive on July 1 1945

Immediate cause of death	DURATION
Valvular heart disease, mitral stenosis.	
Due to: Auricullar Fibrillation	
Due to:	
Other conditions: Subacute bacterial endocarditis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Gordon R. Lynch, M. D. or other

Address: Nat. Nav. Med. Center, Bethesda Date signed: 7-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

07105

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3133 Conn. ave. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Jesse Mabelle Doran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1866

8. AGE: Years	Months	Days	If less than one day
79	—	10	hrs. min.

9. Birthplace: Minn.
(Town, county, and state)
10. Usual occupation: at home
11. Industry or business: home

FATHER
12. Name: Michael Dreisbach
13. Birthplace: Dodge Center, Minn.

MOTHER
14. Maiden name: Louise Fulton Dreisbach
15. Birthplace: Dodge Center, Minn.

16. Informant: Records Washington San. & Hospital
Address: Takoma Park, Md.

17. cremation (Burial, cremation, or removal. Which?) Date thereof: Aug 2, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Lincoln
Location: Dr. Isle. County
18. Funeral director: W. W. Chamberlin Co
Address: 1400 Chapin St. N.W.

19. July 27 1945 (Date rec'd by registrar) Josephine McScharfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1945 at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1945 to July 23 1945 and that I last saw her alive on July 1 1945

Immediate cause of death	DURATION
Congestive Cardiac Failure	6 mos.
Due to: Arteriosclerosis	? years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert A. Hare M.D.
M. D. or other
Address: Takoma Park, Md. Date signed: 7/23/45

3888

07106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 Rolling Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Margaret Fallowfield

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Frank J.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 3, 1866

8. AGE: Years	Months	Days	If less than one day
79	11	15	..... hrs. ..... min.

9. Birthplace: Doylestown, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Wm Alberger
13. Birthplace: md
MOTHER 14. Maiden name: Higgins
15. Birthplace: Md.
16. Informant: Frank P. Fallowfield
Address: Same home

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/21/45 (month) (day) (year)
Cemetery or crematory: Sudbrook Md. Cem.
Location: Sudbrook Md
18. Funeral director: Wm Reuben Dunphrey
Address: 7557 Wis. Ave. Bethesda 14 Md.
19. 7-21-45 19..... [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1945, at 10 15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Dep. Med. Exam care 19.... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute cardiac dilatation	2 hrs.
Due to: Fracture L. hip	6-24-45
Due to: (accidental)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 6-24-45
Where did injury occur? Chevy Chase (City or town) Montg. (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Fall Injured at work? no

23. SIGNATURE: Frank J. Broschart MD.
Dep. Med. Exam M. D. or other
Address: Gaithersburg Md. Date signed 7-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

★ 07107 Reg. Diat. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 105 Westmoreland Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 Westmoreland Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Arthur F Folger, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith M. Folger
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): February 24, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	4	28		

9. Birthplace: Nantucket Island, Mass. (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: General Conf. S.D.A.
12. FATHER — Name: George W. Folger
13. Birthplace: Fayal, Western Islands
14. MOTHER — Maiden name: Emaline Eldridge
15. Birthplace: Massachusse Mass.
16. Informant: Arthur F. Folger, Jr.
Address: 105 Westmoreland, Takoma PK Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24 1945 (month) (day) (year)
Cemetery or crematory: GEORGE WASH. MEMORIAL CEMETERY
Location: Riggs Road, R.F.D. Hyattsville, Md. Pr. Geo. Co.
18. Funeral director: J. ARTHUR WALTERS
Address: 254 CARROLL ST. N.W. TAKOMA PARK, D.C.
19. 7/22 1945 (Date rec'd by registrar) J. Holmes Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1945 at 9 16 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945, to July 20 1945
and that I last saw him alive on July 20 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Arterio sclerosis and Hyper tension	
Due to:	
Other conditions: Aortic regurgitation	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wallace U. Mook M.D.
M. D. or other
Address: 805 Carroll Avenue Takoma Park, Md. Date signed: 7-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07108

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montg
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs.
Hospital, institution, or street address where death occurred:
4712 Drummond Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montg.
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4712 Drummond Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hugh MacNash Frampton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Helen W.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2, 1893

8. AGE: Years	Months	Days	If less than one day
52.			..... hrs. ..... min.

9. Birthplace Fowling Creek, Caroline Co. Md.
(Town, county, and state)
10. Usual occupation Lawyer
11. Industry or business
FATHER 12. Name Robert Snow Frampton
13. Birthplace Caroline Co. Md.
MOTHER 14. Maiden name Nettie Mc Nash
15. Birthplace Caroline Co. Md.
16. Informant Hugh Frampton Jr.
Address Son 4712 Drummond Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/45 (month) (day) (year)
Cemetery or crematory Easton Cem.
Location Easton, Maryland
18. Funeral director Wm Reuben Humphreys
Address 7557 Wis. Ave. Bethesda
19. 7/11 1945 Wm E. Johns MD Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945 at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam care 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary occlusion	dail
Due to	suddenly
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bronkart M.D.
M. D. or other
Address Gaithersburg Md. Date signed 7-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BK)

CERTIFICATE OF DEATH

★ 07109 Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montg Co.
City or town: Gaithersburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George William Gates

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Emma Peck
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 30/1851

8. AGE: Years	Months	Days	If less than one day
93	6	18	hrs. min.

9. Birthplace: Penn,
(Town, county, and state)
10. Usual occupation: Retired Farm er
11. Industry or business

FATHER
12. Name: Harvey Gates
13. Birthplace: Penn

MOTHER
14. Maiden name: Lousa Star
15. Birthplace: Penn

16. Informant: Mrs Leslie Johnson
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/45 (month) (day) (year)
Cemetery or crematory: Fair View Cemetery
Location: Coffeyville, Kansas
16. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. July 19 1945 (Date rec'd by registrar) Abude L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18th 1945 at 2 20P M

21. I CERTIFY that I attended the deceased from May - 1 - 1945 to July - 18 - 1945
and that I last saw h[illegible] alive on July 18 - 1945

Immediate cause of death	DURATION
Cardio - nephritis	2½ mos
Due to: Arteriosclerosis	3 months
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William E Miller, M.D.
M. D. or other
Address: Gaithersburg Md Date signed: 7/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07110

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? (37 days in Md.)

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hosp.

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Ohio County: Ashland

City or town: Ashland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 230 E. 3rd. St.

(If rural, give LOCATION)

2.(a) If veteran, name war: X ✓

3. (a) FULL NAME: MRS IDA GERBER

3. (b) Social Security Number: X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Wm. H.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12th. 1879

8. AGE: Years	Months	Days	If less than one day
66	4	15	..... hrs. ..... min.

9. Birthplace: Ashland Co. Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Abraham Myers

FATHER 13. Birthplace: Ashland Co. O.

MOTHER 14. Maiden name: Hannah Fast

MOTHER 15. Birthplace: Ashland Co. O.

16. Informant: Ralph Barnhart (son in law)

Address: Rockville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/28/45 (month) (day) (year)

Cemetery or crematory: Ashland

Location: Ashland, Ohio

18. Funeral director: Wane E Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. July 27 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4th 1945, to July 27 1945

and that I last saw her alive on July 27 1945

Immediate cause of death	DURATION
Typhoid fever	4 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Esther E. Kuhn M.D. M. D. or other

Address: Rockville, Md. Date signed 7/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

07111

★ Reg. Diat. No. 1223

1. PLACE OF DEATH:

County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo

Hospital, institution, or street address where death occurred:

404 Holly Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 404 Holly Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish Am. & 1st World war

3. (a) FULL NAME: James Gilodley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 11, 1871

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace: Durham Co. England

(Town, county, and state)

10. Usual occupation:

11. Industry or business: Retired soldier

FATHER 12. Name: no records

13. Birthplace

MOTHER 14. Maiden name: no records

15. Birthplace

16. Informant: Sadie G. Moody

Address: 404 Holley Ave Takoma Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 28 1945 (month) (day) (year)

Cemetery or crematory: Columbia Memorial

Location:

18. Funeral director: Wm Leip Son Co

Address: 3000 - 4 St N.E.

19. 7/26 1945 (Date rec'd by registrar) J. Thrudley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1945 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Some yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broerhart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 7-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07112

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery / Washington Sanitarium
City or town: Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 98 Days
Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital
How long in hospital or institution? 98 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 719 - 19th St N.W. Apt 36
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Green, Miss Leila

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): February 25, 1885

8. AGE:	Years	Months	Days	If less than one day
	60	4	25	... hrs. ... min.

9. Birthplace: New York City N.Y.
(Town, county, and state)
10. Usual occupation: Office Clerk
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

Information Not available

16. Informant: Washington Sanitarium and Hospital
Address: Takoma Park, Maryland

17. Removal — Date thereof: July 20 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Cedar Hill — July 24, 1945
Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co
Address: 1400 Chapin St N.W. Wash. D.C.

19. July 20 1945 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25 1945, to July 20 1945
and that I last saw her alive on July 19 1945

Immediate cause of death	DURATION
Carcinoma of right breast	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Linwood Haiges M.D.
M. D. or other
Address [illegible] ... Date signed [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

07113

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? four days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? four days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wis. County:

City or town: Colby
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HENKEL, Clarence Alexander, Pvt. USMCR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 July 1924

8. AGE: Years	Months	Days	If less than one day
21	0	11	hrs. min.

9. Birthplace: N.Y.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: Gust Henkel
13. Birthplace: Colby, Wis.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Father: Mr. Gust Henkel
Address: Colby, Wis.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 7-17-45 (month) (day) (year)

Cemetery or crematory:

Location: Colby, Wis.

18. Funeral director: Geo. M. Wise, J.C.F.
Address: 2900 M St., N. W., Wash., D.C.

19. 7-16- 19 45 (Date rec'd by registrar) mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 July 19 45 at 12:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 July 19 45, to 15 July 19 45 and that I last saw h.. im.. alive on 15 July 19 45

Immediate cause of death	DURATION
acute tuberculous meningitis.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: acute tuberculous meningitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Sumner F. Eckard M.D. M. D. or other

Address: USNH - Bethesda Date signed: 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

07114

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6200 Marlborough Pike
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HILL, Mildred Grantham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: John Hill, PhoMlc USNR

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 Jan. 1909

8. AGE: Years	Months	Days	If less than one day
36	5	23	hrs. min.

9. Birthplace: Ala.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Bryan Grantham

FATHER — 13. Birthplace: Fla.

MOTHER — 14. Maiden name: Ozie Howell

MOTHER — 15. Birthplace: Ala. (deceased)

16. Informant: husband: John Hill, PhoMlc USNR

Address: 6200 Marlborough Pike, Hillside, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7-18-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Md.

18. Funeral director: W. W. Chambers Per J.D.L.

Address: 517 11th St., S.E., Wash., D. C.

19. 7-16- 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 July 1945 at 4:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 June 1945, to 16 July 1945 and that I last saw her alive on 16 July 1945

Immediate cause of death	DURATION
Peritonitis, Acute, General	20 days
Due to: Perforated Gastric Ulcer	27 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Perforated gastric ulcer Subdiaphragmatic Pelvic Abscess Date of op. 6/19-6/24 7/14

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. W. Robinshaw H. W. ROBINSHAW, Lt. Cdr. (MC) USNR M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 7-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B) +

07115

CERTIFICATE OF DEATH

★ Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 3½ mts.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Theodore Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 24, 1884

8. AGE: Years 60 | Months 10 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Mt. Zion, Montg. Co. Md.

(Town, county, and state)

10. Usual occupation Houseman-

11. Industry or business —

FATHER 12. Name John Johnson

13. Birthplace —

MOTHER 14. Maiden name Sarah Lincoln

15. Birthplace —

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 1945 (month) (day) (year)

Cemetery or crematory Mt. Zion Bury

Location Montgomery Co. Md.

18. Funeral director Ray W. Barber

Address Rockville Md.

19. July 28 1945 (Date rec'd by registrar) Dr. Frank K. Lawton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1945 19..... at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1945, to July 28 1945 and that I last saw him alive on July 28 1945

Immediate cause of death	DURATION
Carcinoma of the Stomach	1 yr.
Due to General Metastasis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 7/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G97 AUG 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

CERTIFICATE OF DEATH

07116

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 5 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County:
City or town: Cleveland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2649 E. 45th Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JONES, Edward (n), StM2c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mrs. Alberta Jones
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3 June ~~1903~~ 1918

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
27	1	15		

9. Birthplace: Miss. (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Oisborn Jones
13. Birthplace: Miss. (deceased)

MOTHER
14. Maiden name: Rebecca Morgan
15. Birthplace: Miss.

16. Informant: wife: Mrs. Alberta Jones
Address: 2649 E. 45th St., Cleveland, Ohio

17. removal (Burial, cremation, or removal. Which?) Date thereof: 7-18-45 (month) (day) (year)
Cemetery or crematory: Peter Moore
Location: Water Valley, Mississippi

18. Funeral director: Thomas Frazier — E E Jones
Address: 389 Rhode Island Avenue, N. W.

19. 7-18- 1945 (Date rec'd by registrar) — Mary Charlotte Smith — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 July 1945, at 9:06A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Feb. 1945, to 18 July 1945 and that I last saw him alive on July 18 1945

Immediate cause of death	DURATION
Tuberculosis - Generalized	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. A. D. Smith, Comdr. (MC) USNR
M. D. or other
Address: US Naval Hospital, Bethesda Date signed:

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

F 07117

CERTIFICATE OF DEATH ★

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md. (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mons 8 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 mons 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Calif. County:

City or town: Modesto
(If outside city or town limits, write RURAL and give nearest town)

Street No. 720 2nd St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JONES, Hubert Kenneth, AMMlc USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 April 1917

8. AGE: Years	Months	Days	If less than one day
28	2	21	hrs. min.

9. Birthplace: Calif. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: M. B. Jones
13. Birthplace: Calif.

MOTHER
14. Maiden name: Emma Post
15. Birthplace: Calif.

16. Informant: Mother: Mrs. Emma Jones
Address: 720 2nd St., Modesto, Calif.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 7-8-45 (month) (day) (year)

Cemetery or crematory:

Location: Modesto, Calif.

18. Funeral director: Geo. W. Wise, Undertaker J.C.F. X

Address: 2900 M St., N. W., Wash., D.C.

19. 7-8-45 (Date rec'd by registrar) 19 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 July 19 45 at 0710a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Feb. 19 45 to 8 July 19 45 and that I last saw him alive on 8 July 19 45

Immediate cause of death: malignant melano-sarcoma with massive abdominal involvement: melanomatosis

DURATION

Due to: Primary on posterior chest, right s.w.l. & R.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. C. Wilder
T. C. WILDER, Lt. (MC) USNR
M. D. or other

Address: US Naval Hospital Date signed: 7-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

★ 07118

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington San. & Hosp.

How long in hospital or institution? Upon Arrival 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: 707 Chaney Drive, Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 707 Chaney Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mr. Richard Kearney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 18, 1929

8. AGE: Years: 16 yrs. Months: 3 Days: 5 (If less than one day) ..... hrs. ..... min.

9. Birthplace: Chicago, Ill.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER — 12. Name: Philip Eugene Kearney

13. Birthplace: Austin, Minn.

MOTHER — 14. Maiden name: Alma B. Duenow

15. Birthplace: E. Amoger, Iowa

16. Informant: Philip Eugene Kearney

Address: 707 Chaney Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25-45 (month) (day) (year)

Cemetery or crematory: Gen. Meml. Mem. Cemetery

Location: Riggs Road

18. Funeral director: Takoma Funeral Home — Richard Walker

Address: 254 Carroll St. N.W. D.C.

19. July 24 1945 (Date received by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Fracture of skull with intra cranial hemorrhage	20 min.
Due to (Accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 7-23-45

Where did injury occur? Takoma Park (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Sligo Creek Dam

Means of injury: Struck head while swimming Injured at work? no

23. SIGNATURE: Frank J. Brosnahan M.D. M. D. or other

Address: Dep. Med. Exam. Gaithersburg, Md. Date signed: 7-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07119

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2227 20th St., N. W., Wash., D C
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: LEMLY, Harriet Porter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife: Capt. Samuel C. Lemly
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1 July 1870

8. AGE:

Years	Months	Days	If less than one day
75	0	24	..... hrs. ..... min.

9. Birthplace: Me. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Frank Milliken
13. Birthplace: Me. (dec.)

MOTHER
14. Maiden name: Ellen Porter
15. Birthplace: Me.(dec.)

16. Informant: Mother: Miss Ellen Lemly
Address 2227 20th St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7-27-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS R. Lamb
Address 1400 Chapin St., N. W., Wash., D.C.

19. 7-25 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 July 19 45, at 2:55a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 July 19 45, to 25 July 19 45
and that I last saw her alive on ..... 19.....

	DURATION
Immediate cause of death: Bronchopneumonia	1 week
Due to: with Coronary Heart Disease	Unknown
Due to: and Chronic Congestive Failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.
Autopsy results: No Autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: G. R. Lamb G. R. LAMB, Lt.Cdr.(MC) USNR
M. D. or other
Address US N.H., BETHESDA, Md. Date signed 7-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

07120

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wave Barracks,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Girl LESS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 27 July 1945

8. AGE: Years	Months	Days	If less than one day
			1 hrs. min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business
FATHER 12. Name: unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: Shirley Anne Less
15. Birthplace: Mass.
18. Informant: Mother: Shirley Anne Less
Address: US N.H., Bethesda, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 7-28-45 (month) (day) (year)
Cemetery or crematory: George Washington Memorial
Location: Md.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin St., N. W., Wash., D.C.
19. 28 July 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 July 1945, to 27 July 1945 and that I last saw h... alive on 27 July 1945

	DURATION
Immediate cause of death: prematurity	
Due to: premature birth	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. Clay Barton M. D. or Coroner
Address: USNH Bethesda Md. Date signed: 7-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G 97 AUG 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

CERTIFICATE OF DEATH

07121

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Mont.

City or town: Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2608 - 36th. St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Kate M. Linton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Erwin B Linton

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1853

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
92.	4			

9. Birthplace: Bluebell. Phila (Town, county, and state)

10. Usual occupation: house wife

11. Industry or business

FATHER — 12. Name: Samel Linton

13. Birthplace: Phil

MOTHER — 14. Maiden name: Catherine Helffenstein

15. Birthplace: Blue Bell, Phila Pa

18. Informant: Mable. Linton

Address: 2608. 36st NW

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18, 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek Cem

Location: Md. Nash. D. C.

18. Funeral director: J William Leedom

Address: 300-4th st N.E. Washington D.C.

19. 7/16 19 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 19 45, at 12:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1937 19 , to July 16 19 45

and that I last saw h er alive on July 16 19 45

Immediate cause of death	DURATION
Diabetes mellitus	8 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: I P. Hammond Mich M. D. or other

Address: 1726 Eye St N.W. Date signed: July 16, 194

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

07122

CERTIFICATE OF DEATH

★ Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Monty
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: wilson Lane & Pinkie Rd. Bethesda
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 319 South Market
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Washington Lydard

3.(b) Social Security Number: 216-22-7919

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

B.(b) Name of husband or wife
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 12, 1927

8. AGE:

Years	Months	Days	If less than one day
18	1	9	..... hrs. ..... min.

8. Birthplace: Leonidale, Montgomery Co., Maryland (Town, county, and state)
10. Usual occupation: Signal Dept. B & O Railroad
11. Industry or business

FATHER
12. Name: George Watson Lydard
13. Birthplace: Damascus, Montgomery Co, Md.

MOTHER
14. Maiden name: Nellie Louise Sullivan
15. Birthplace: Poolesville, Montgomery Co, Md.

16. Informant: Mrs. George H. Lydard
Address 319 So market, Frederick, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23. 1945 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Frederick Md
18. Funeral director Roy W Barber
Address Poolesville Md

19. 7/24/45 (Date rec'd by registrar) Wm E Dobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dep. Med. Exam 19.. to 19.. and that I last saw h.. alive on .. 19..

Immediate cause of death	DURATION
Fracture of skull with contus-cranial hemorrhage	10 min.
Due to accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op. 7-21-45
Autopsy results Denied as usual
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 7-21-45
Where did injury occur? Bethesda (City or town) Monty (County) md (State)
Injured at home, farm, industry, public place (where?) highway
Means of injury auto Injured at work? no

23. SIGNATURE Frank J. Brochat M.D. M. D. or other
Address Dep. Med. Exam. Montgomery md Date signed 7-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

07123

CERTIFICATE OF DEATH

★ Reg. Diat. No. 213-

1. PLACE OF DEATH:
County: Moulgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: 319- Braell Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Moulgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 319- Braell Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Grace Colburn Markland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles E. Markland
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 31- 1883

8. AGE: Years	Months	Days	If less than one day
61	5	13	hrs. min.

8. Birthplace: Poco moke City - Maryland (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own home
FATHER 12. Name: Charles A Colburn
13. Birthplace: Oak Hill Virginia
MOTHER 14. Maiden name: Emma R Virginia
15. Birthplace: Poco moke City - Md.
16. Informant: Glenn Bartlet (Son in Law)
Address: 319- Braell Ave - Rockville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Friday 7/14/45 (month) (day) (year)
Cemetery or crematory: Rockville Union
Location: Dr. Rockville - Maryland
18. Funeral director: Wm. Reuben Dunphrey
Address: Rockville - Maryland
19. 7/13/45- (Date rec'd by registrar) Josephine D. Thurston Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Friday 13th 19 45, at 11-35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 44, to July 13 19 45
and that I last saw her alive on July 13 19 45

Immediate cause of death	DURATION
CARCINOMA OF CERVIX	1 Year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William A. Weibel, M.D.
Address: Rockville, Md. M. D. or other
Date signed: 7/13/45

M
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T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

07124

CERTIFICATE OF DEATH

★ Reg. Dist. No. 213-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo
Hospital, institution, or street address where death occurred: Chestnut Lodge Sam.
How long in hospital or institution? 2 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2480 16th St N.W
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Alice T. McKee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Samuel McKee
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27 1908

8. AGE:

Years	Months	Days	If less than one day
36	11	23	..... hrs. ..... min.

9. Birthplace: Texas
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John McWhorter Trotter
13. Birthplace: Texas.

MOTHER
14. Maiden name: Maud Williams
15. Birthplace: Ga.

16. Informant: Chestnut Lodge Sam. (records)
Address: Rockville Md

17. Placed in Vault (Burial, cremation, or removal, Which?) Date thereof: July 21-1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cem.
Location: Maryland

18. Funeral director: Wm. Reuben Sumption Sons
Address: Rockville - Maryland

19. 7/21/45 Josephine D Hatton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 19 45, at 9:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia by strangulation (suicide)	Instant death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 7-20-45
Where did injury occur? Rockville (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed 7-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

07125

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days.

Hospital, institution, or street address where death occurred:
Bethesda Suburban Hospital

How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6709 N. Central Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine Ann Moore.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White	Widowed.

8.(b) Name of husband or wife: William George Moore.

8.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1871

8. AGE: Years	Months	Days	If less than one day
43	8	25	____ hrs. ____ min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Francis Salon Mc Mahony
13. Birthplace: Fairfax, Va.

MOTHER
14. Maiden name: Mary Collins
15. Birthplace: Dublin, Ireland.

16. Informant: Mrs. James A. O'Donnell
Address 6709 N. Central Ave., Ch. Ch., Md.

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 7/7/45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: W. W. Chambers
Address 3 Th & M. N. W.

19. 7/7 19 45 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/7/ 19 45 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 42 to death 19 45 and that I last saw her alive on 7-6-45 19 45

Immediate cause of death	DURATION
Terminal pneumonia	
Acute Cardiac Collapse	3 days
Due to: Hypertensive Cardio-Renal Disease	yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: C. M. Flowers, M. D.
M. D. or other

Address: Silver Spring, Md. ____ d.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07126

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

1919 Glen Ross Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1919 Glen Ross Road

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: James H. Fullilove Myrick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elizabeth C.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 15th 1889

8. AGE: Years	Months	Days	If less than one day
53.	8	12.	..... hrs. ..... min.

9. Birthplace: Milledgeville Ga.

(Town, county, and state)

10. Usual occupation: Adm Asst. Interior Dept.

11. Industry or business: U.S Government.

FATHER

12. Name: James W. Myrick

13. Birthplace: Ga

MOTHER

14. Maiden name: Nulia K. Whitehurst

15. Birthplace: Ga.

16. Informant: Mrs Elizabeth C Myrick.

Address: 1919 Glenross Rd. Silver Spring

17. Removal. (Burial, cremation, or removal. Which?) Date thereof: 7-29-45. (month) (day) (year)

Cemetery or crematory: Milledgeville

Location: Milledgeville Baldwin Co. Ga.

18. Funeral director: Warren & Pumphrey.

Address: 8136 Ga Ave. Silver Spring. Md

19. July 28 1945 Josephine M Schaffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945, at 5.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 7-27-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (196)

CERTIFICATE OF DEATH ★

07127

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County:

City or town: Watervliet,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1558 Avenue "A"
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Donald Francis O'HARE, Pfc USMCR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6 1925 20

8. AGE:	Years	Months	Days	If less than one day
	19	2	1	hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business

FATHER
12. Name: Robert Francis O'Hare
13. Birthplace: New York

MOTHER
14. Maiden name: Mae Edna Burns
15. Birthplace: New York

16. Informant: Father: Mr. Robert F. O'Hare
Address: 1558 Avenue "A", Watervliet, N.Y.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-6-45 (month) (day) (year)

Cemetery or crematory:

Location: Troy, New York

18. Funeral director: Geo. W. Wise, Co. J.C.F.

Address: 2900 M St. N.W., Washington, D.C.

19. July 6 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 July 1945, at 1838p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 June 1945, to 6 July 1945 and that I last saw him alive on 6 July 1945

Immediate cause of death	DURATION
Bronchopneumonia and bacteremia staphylococcus	
Due to Gunshot wound of brain: Shrapnel. Cerebral	
Due to During operations of War, March 14th, 1945, on Iwo Jima	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Encephalomalacia No brain abscess Date of op. 21 June, 1945

Autopsy results: 26 July, 1945

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. U. [illegible], Lt. Comdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 7-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

07128

CERTIFICATE OF DEATH

★ Reg. Dist. No. 212

1. PLACE OF DEATH.

County Montgomery

City or town Beallsville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

—

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Beallsville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Owens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7/16/45

8. AGE: Years | Months | Days | If less than one day: 3 hrs. ..... min.

9. Birthplace Beallsville, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER — 12. Name Charles C. Owens

13. Birthplace Montgomery Co. Md

MOTHER — 14. Maiden name Annie Moore

15. Birthplace Montgomery Co., Md

16. Informant Charles E. Owens

Address Beallsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17-45 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Beallsville, Md.

18. Funeral director Wm B. Hilton

Address Barnesville, Md.

19. July 17 1945 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. C. C. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 – 1945 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 – 1945 – to July 16 – 1945 – and that I last saw h... alive on July 16 – 1945 –

Immediate cause of death	DURATION
Premature birth – 6 mos +	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Byron D. White M.D.
M. D. or other

Address Barnesville, Md. Date signed 7/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07129

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E) ★

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: (Bethesda, rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos & 26 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn iofaota give residence of mother)
State: Md. County:
City or town: Chevy Chase,
(If ootside city or town limits, write RURAL and give nearest town)
Street No. 6804 Brookville, Road
(If roral, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: PARRISH, Charles Jefferson, Captain USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife: Mrs. Charles J. Parrish
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9-14-89

8. AGE:	Years	Months	Days	If less than one day
	55	10	12	....hrs. ....min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business
FATHER 12. Name: Charles C. Parrish
FATHER 13. Birthplace: Va. (deceased)
MOTHER 14. Maiden name: Mildred Lewis
MOTHER 15. Birthplace: Ky. (
16. Informant: daughter: Miss Mildred L. Parrish
Address: Holland's College, Hollands, Va.
17. removal (Burial, cremation, or removal. Which?) Date thereof 7-28-45 (month) (day) (year)
Cemetery or crematory: Rosecran Nat'l. Cem.
Location: San Diego, California
18. Funeral director: Geo. W. Wise, J.C.F.
Address: 2900 M St., N. W., Wash., D.C.
19. 7-26- 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 July 19 45, at 3:40a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 May 19 45, to 26 July 19 45 and that I last saw h...im...alive on 26 July 19 45

	DURATION
Immediate cause of death: Carcenamatoses	3 MOS.
Due to: Carcinoma colon	7 MOS.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma colon with metastases Date of op. 7/25/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. C. Hanssen cdr(MC)USNR M. D. or other
Address: US N.H., Bethesda, Md. Date signed 7-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

07130

CERTIFICATE OF DEATH

★ Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Montgomery

City or town: Sandy Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Sandy Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary T. Phoenix

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1856

8. AGE:

Years	Months	Days	If less than one day
89	4	12	..... hrs. ..... min.

9. Birthplace: maryland.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER 12. Name: Richard Snowden

FATHER 13. Birthplace: maryland.

MOTHER 14. Maiden name: Harriett Hawkins

MOTHER 15. Birthplace: maryland.

16. Informant: Bernard Phoenix

Address: 505 W Huffman St Baltimore md

17. Buried — Date thereof: July 5, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Sandy Spring

Location: Sandy Spring, Md.

18. Funeral director: Robert L. Snowden

Address: 246 - N. Wash. St Rockville

19. July 2, 1945 Gertrude K. Farquhar Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 — 1945, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 — 1945 to July 1 — 1945 and that I last saw her alive on July 1 — 1945

Immediate cause of death: Cerebral Hemorrhage — DURATION: 20 min.

Due to:

Due to:

Other conditions: Diabetes Mellitus — 25 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. E. Tompkinson M. D. or clerk

Address: Sandy Spring Md. Date signed: 7/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

CERTIFICATE OF DEATH

07131

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 minutes

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edwin Prather

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Infant.

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 16, 1945 3:15 A.M.

8. AGE: Years — Months — Days 0 If less than one day 0 hrs. 2 min.

9. Birthplace: Gaithersburg Montgomery Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER

12. Name: Joseph Prather

13. Birthplace: Gaithersburg, Md

MOTHER

14. Maiden name: Elizabeth Nolan

15. Birthplace: Gaithersburg, Md

16. Informant: Elizabeth Nolan

Address: Gaithersburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16-45 (month) (day) (year)

Cemetery or crematory: Home

Location: Gaithersburg, Md.

18. Funeral director: Joseph Prather

Address: Gaithersburg, Md.

19. July 16 1945 (Date rec'd by registrar) Alfreda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 19 45, at 3:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 45, to July 16 19 45

and that I last saw him alive on July 16 19 45

Immediate cause of death	DURATION
Conflagration	
Due to: Umbilical cord around neck.	
Due to: Born before arrival of physician	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. Shirley M.D.
M. D. or other

Address: Gaithersburg Date signed: July 16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07132

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Monty.
City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred: 8583 Locust Hill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty.
City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8583 Locust Hill Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Ruth Pomeroy Pratt | **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Oliver Garrett
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec. 19, 1870

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace: New York City (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Dr. Oren Day Pomeroy
FATHER 13. Birthplace: Conn.
MOTHER 14. Maiden name: Hannah M. Miles
MOTHER 15. Birthplace: Brooklyn, N. Y.
16. Informant: Mr. Oliver Garrett Pratt
Address: 179 South Harrison St. East Orange N.J.
17. Interment (Burial, cremation, or removal. Which?) Date thereof 7/27/45 (month) (day) (year)
Cemetery or crematory: Green Wood Cem.
Location: Brooklyn, N. Y.
18. Funeral director: Lor Heuben Humphrey
Address: 7557 Wis. Ave. Bethesda
19. 7/27/45 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1945, at 2:48 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944, to July 25 1945
and that I last saw her alive on July 25 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION
Due to: Hypertension
Due to: Cardiac renal insufficiency
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?
23. SIGNATURE: Frank Jaggers M.D. M. D. or other
Address: 8016 Draytan Rd. Date signed 7/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

67133

CERTIFICATE OF DEATH

Reg. Dist. No. 123-

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred: Washington Sanitarium et Hospital, Takoma Park, Md.

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1669 Columbia Rd. N.W. Apt. 210
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Ella Purdy

3.(b) Social Security Number

4. Sex Fe

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 13, 1860

8. AGE: Years 85 Months 4 Days 3 If less than one day ... hrs. ... min.

9. Birthplace Penn Yan, New York
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Deceased
13. Birthplace

MOTHER
14. Maiden name Deceased
15. Birthplace

16. Informant Washington Sanitarium & Hospital

Address Takoma Park, Md.

17. Removal Date thereof 7/16/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director S.H. Hines Co.

Address 2901 - 14th St. N.W.

19. 7/16 1945 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 1943 to July 16 1945 and that I last saw her alive on July 16, 1945

Immediate cause of death Cerebral hemorrhage — DURATION 23 days

Due to Right hemiplegia — 19 days in hospital

Due to

Other conditions Arthritis, chr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide ... Date of

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE [signature] M.D. or other

Address 5[illegible] Underwood St. N.W. Date signed 7/1[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

07134

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Wash. County:

City or town: Camas
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 Northwest Benton Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RANCORE, Thelma Althea, St.Sgt. USMC(WR)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5 Nov. 1915

8. AGE: Years	Months	Days	If less than one day
29	9	7	hrs. min.

9. Birthplace: Idaho
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: William H. Rancore
13. Birthplace: Mich.

MOTHER
14. Maiden name: Effie Bills
15. Birthplace: Ore.

16. Informant: Mother: Mrs. William Rancore

Address: 1320 Northwest BentonSt., Camas, Wash.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7-16-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Geo. A. Wise, Undertaker JCF

Address: 2900 M St., N. W., Wash., D. C.

19. 7-13 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 July 19 45 at 4:12 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 July 19 45, to 12 July 19 45

and that I last saw her alive on 12 July 19 45

	DURATION
Immediate cause of death: Bronchopneumonia	3 days
Due to:	
Due to:	
Other conditions: Septicaemia	one wk

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Bilateral complete bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

H. J. Davis

23. SIGNATURE: H. J. Davis, Lt. (MC) USNR(WR)
M. D. or other

Address: US NAVAL HOSPITAL, Bethesda, Md. Date signed: 7-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 7/15/45

STATE OF MARYLAND—CERTIFICATE OF DEATH 07135

(13-a)

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 214

Village or City Silver Spring. No. 605 Mississippi Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where deeth occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME SENNIE ROBICHAUD If U. S. Veteran, specify WAR ___

(a) Residence: No. 605 MISSISSIPPI AVE St., Ward. ___

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Widowed

5a. If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Nelson G. Robichaud.

6. DATE OF BIRTH (month, day, and year) 1859

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	86	—	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation ___

12. BIRTHPLACE (city or town) (State or country) Mass

FATHER

13. NAME LEWIS PLOULL

14. BIRTHPLACE (city or town) (State or country) Canada.

MOTHER

15. MAIDEN NAME ADA LANEDGIN

16. BIRTHPLACE (city or town) (Stete or counlry) Canada.

17. INFORMANT Sarah J. Oliver. (Address) 2406-33rd n.a. Wash. D.C.

18. BURIAL, CREMATION, OR REMOVAL? Place Washington, D.C. Date July 24, 1945

19. UNDERTAKER T. F. Costello. (Address) 1722 North Capitol St.

20. FILED July 24, 1945 Josephine M. Schaeffer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 7/24/45 (Month) (Day), 193 (Yeer)

22. I HEREBY CERTIFY, That I attended deceased from March 4 1945 to 7/23/45, 19___

I last saw h~~er~~ alive on 7/20/45, 19___; deeth is said to have occurred on the date steted above, at 6 A.M.

The PRINCIPAL CAUSE OF DEATH end related causes of importance were es follows:

	Date of onset
Uremia	3-4 week

Other Contributory Causes of importance:

Hypertension Arteriosclerosis

Neme of operation ___ Date of ___

Whet test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, sulcide, or homicide? ___ Date of injury ___, 19___

Where did Injury occur? ___ (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) John J. Sweeney M.D.

(Address) 1238 Monroe St

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (745)

07136

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mons & 6 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: La. County:

City or town: New Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 241 Chatres St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: SCHWALM, Thomas Glenmore, Lt.(jg) A-1 USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-4-20

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24	10	25		

9. Birthplace: Ga.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER — 12. Name: T. E. Schwalm

13. Birthplace: Mich.

MOTHER — 14. Maiden name: Gladys Hays

15. Birthplace: Ga.

16. Informant: Fa: Mr. T. E. Schwalm

Address: 241 Chatres St., New Orleans, La.

17. (Burial, cremation, or removal. Which?): removal Date thereof: 7-30-45 (month) (day) (year)

Cemetery or crematory:

Location: Decatur, Ga.

18. Funeral director: Geo. W. Wise, 2900 M St., N.W. JCT

Address: Washington, D. C.

19. (Date rec'd by registrar): 7-30 1945

Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 July 1945, at 2:01 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 May 1945, to 29 July 1945 and that I last saw him alive on 29 July 1945

Immediate cause of death	DURATION
Leukemia, acute myelogenous	5 mons.
Due to:	
Due to:	
Other conditions: Pneumonia, bronchopneumonia	2 days.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ferdinand E. Blatard Lt. Cdr. (MC) USNR
M. D. or other

Address: US Naval Hospital, Bethesda, Md. Date signed: 7-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07137

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING - RFD 2.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. VA. County: MINERAL

City or town: KEYSER.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 164 - E PIEDMONT ST.
(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3. (a) FULL NAME: CONSTANCE LOUISE SHINN.

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE.	WHITE.	SINGLE

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): SEP-27TH 1931.

8. AGE: Years	Months	Days	If less than one day
13.	10	14.	____ hrs. ____ min.

9. Birthplace: PITTSBURG - PA.
(Town, county, and state)

10. Usual occupation: STUDENT.

11. Industry or business:

FATHER
12. Name: HUGH S SHINN.
13. Birthplace: BUCHANON - W.VA.

MOTHER
14. Maiden name: EVELYN T THORNHILL.
15. Birthplace: BELLINGTON W. VA.

16. Informant: HUGH SHERWOOD SHINN.
Address: RFD - 2 - SILVER SPRING - MD

17. REMOVAL
(Burial, cremation, or removal. Which?)
Date thereof: 7 - 13 - 45
(month) (day) (year)

Cemetery or crematory: QUEEN POINT.

Location: KEYSER - W. VA.

18. Funeral director: Davis & Pumphrey

Address: 8436 Ga Ave Silver Spring - Md.

19. July 12 19 45 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 19 45, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam Card, 19__

and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Fracture of skull with Cerebral hemmorhage	died suddenly
Due to: (Accidental)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of: 7-11-45

Where did injury occur? Silver Spring R.F.D. Montg Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Fall from horse Injured at work? no

23. SIGNATURE: Frank J. Brockett M.D.
M. D. or other

Address: Gaithersburg Md. Date signed: 7-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

07138

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 5400 Edgemoor Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LUCIA RITTENHOUSE SHOEMAKER

3.(b) Social Security Number

4. Sex: Female (FEMALE) | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Dr. Chas. G. Shoemaker 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 3rd. 1879

8. AGE: Years: 66 | Months: 2 | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Scranton, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Jas. H. Rittenhouse

13. Birthplace: Wash. D.C.

MOTHER — 14. Maiden name: Ada Cole

15. Birthplace: Unknown

16. Informant: Dr. Chas G. Shoemaker

Address 5400 Edgemoor Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16th 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Wash. D.C.

16. Funeral director: Joseph H. Birch's Sons

Address 3034 M St. N.W. Wash. D.C.

19. 7/13 1945 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1944, to July 13 1945 and that I last saw her alive on July 9 1945

Immediate cause of death	DURATION
Congestive heart failure	
Due to Hypertension and coronary arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr Joseph Kenick M. D. for other

Address 7942 Wisconsin Ave. Date signed 7/13/45

Bethesda, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

0713?

CERTIFICATE OF DEATH ★

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Monty.

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, Institution, or street address where death occurred:
Persimmon Tree Rd.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Monty.

City or town Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. Persimmon Tree Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bertha L. Sipes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Walter W.

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 2, 1887

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Shaw

13. Birthplace Maryland

MOTHER 14. Maiden name Martha Pearl

15. Birthplace Maryland

16. Informant Mrs. Walter Sipes

Address Persimmon Tree Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/9/45 (month) (day) (year)

Cemetery or crematory Potomac Cem.

Location Potomac Md.

18. Funeral director Wm Reuben Dunphrey

Address Bethesda, Md.

19. 7/7 19 45 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to July 5 1945

and that I last saw her alive on July 5 1945

	DURATION
Immediate cause of death Respiratory failure	
Due to Carcinoma Tube Lung with Ascites	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Jaggard M.D.
M. D. or other

Address 8016 Dengton Rd. Date signed 7/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

07140

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital or street address where death occurred:
705 Roeder Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 705 Roeder Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME
AGNES K. STREATOR

3.(b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Frank W.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 1st. 1868

8. AGE: Years	Months	Days	If less than one day
76	10	29	..... hrs. ..... min.

9. Birthplace Middleville, N. Y.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name George Edward Smith
13. Birthplace Middleville, N. Y.
MOTHER 14. Maiden name Bridget Delaney
15. Birthplace Mohawk, N. Y.
16. Informant Mrs. Arley T. Caudill,
Address 805 Roeder Rd. Silver Spring.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/1/45 (month) (day) (year)
Cemetery or crematory Calvery
Location Herkimer, Herkimer Co. N. Y.
18. Funeral director Warner & Pumphrey.
Address 8434 Ga. Ave. Silver Spring. Md.
19. Aug 2 19 45 Joseph Schaefle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 45 at 4:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 19 43 to July 30 19 45 and that I last saw h er alive on July 30 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hrs.
Due to Arteriosclerosis	10+ yrs.
also Severe chronic arthritis Atrophic & hypertrophic	18 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. M. Snell M. D.
M. D. or other
Address Silver Spring Md. Date signed 7/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

07141

CERTIFICATE OF DEATH ★ Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred:
10603 S. Dunmoor Dr.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 10603 S. Dunmoor Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: HAZEL E SWETT

3.(b) Social Security Number: 578-01-2062

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles R.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 29th. 1906

8. AGE: Years	Months	Days	If less than one day
39	5	3	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: Operating Eng'rs Local 77

FATHER
12. Name: Charles Thomas Pratt
13. Birthplace: Deleware

MOTHER
14. Maiden name: Mary L. Turner
15. Birthplace: Maryland

16. Informant: Charles R. Swett (Husband)
Address: 10603 S. Dunmoor Dr.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/5/45 (month) (day) (year)
Cemetery or crematory: Geo. Washington Memorial
Location: Prince Georges Co. Md.

18. Funeral director: Warner E Pumphrey
Address: 8434 Ga. Ave. Silver Spring. Md.

19. July 4th 1945 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 45 at 4:15p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to June 27 19 45 and that I last saw her alive on June 27 19 45.

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Andrews M.D. M. D. or other
Address: 9601 Colesville Rd Silver Spring, Md. Date signed: 7-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80-a)

07142

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or Institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Wash- County
City or town: D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1518 N. J. Ave. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Isiah Tenson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Susie Mae
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 12, 1925

8. AGE:

Years	Months	Days	If less than one day
20	3	24	hrs. min.

9. Birthplace: Atlanta, Georgia (Town, county, and state)
10. Usual occupation: Trucks driver
11. Industry or business

FATHER
12. Name: Joseph Tenson
13. Birthplace: ?

MOTHER
14. Maiden name: Boone
15. Birthplace: ?

16. Informant: Susie Mae Tenson (wife)
Address: 1518 N. J. Ave. N.W. Wash. D.C.
17. (Burial, cremation, or removal. Which?) Removal Date thereof 7/6/45 (month) (day) (year)
Cemetery or crematory: Wash. D.C.
Location
18. Funeral director: Malvaux & Schey
Address: 424 E. St. N.W. Wash D.C.
19. 7/6 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 19 45 at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med Exam, to case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Brain abscess	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Brosnahan M. D.
Sept Med. Exam M. D. or other
Address: Gaithersburg Md. Date signed 7-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

07143

CERTIFICATE OF DEATH ★

Reg. Diat. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Lewisdale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Albert L. Tettlow

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Della Tettlow
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1872

8. AGE: Years	Months	Days	If less than one day
73	4	21	..... hrs. ..... min.

9. Birthplace: Baltimore Co
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Samuel Tettlow
13. Birthplace: Baltimore Co

MOTHER
14. Maiden name: Sarah Gaither
15. Birthplace: Frederick Co

16. Informant: Mrs. Albert Tettlow
Address: Monrovia, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 13, 1945 (month) (day) (year)
Cemetery or crematory: Bethesda
Location: Brunnerville

18. Funeral director: H. M. Snyder
Address: Mt. Airy

19. July 11 19 45 (Date rec'd by registrar) Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1945, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1944 to July 11, 1945 and that I last saw h.i.m. alive on July 9, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage, left	7 Days
Arteriosclerotic cardiovascular disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James P. Kerr M.D.
M. D. or other
Address: Damascus, Md. Date signed: 7/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7210 Radnor Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Thorson (Mary Paula) 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1945

8. AGE: Years | Months | Days 5 | If less than one day hrs. min.

9. Birthplace Bethesda, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Waldemar Thorson
13. Birthplace Minn.

MOTHER 14. Maiden name Charlotte Shea
15. Birthplace Michigan

16. Informant Father
Address 7210 Radnor Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/27/45 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cem.
Location Washington, D.C.

18. Funeral director Wm. Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda

19. 7/28 (Date rec'd by registrar) 19 45 Wm E Jones MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 19 45, at 6 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 19 45 to July 25 19 45 and that I last saw h alive on July 25 45 19

Immediate cause of death	DURATION
Prematurity	
Due to Premature separation of placenta	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Landau MD
M. D. or other
Address 7122 Wisconsin Date signed 7/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

117145

★ Reg. Dist. No. 216

VS A15 (1) (7) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
8403 Irvington Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Monty.
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8403 Irvington Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mr. Roland Stevens Tore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1899

8. AGE: Years	Months	Days	If less than one day
46	6	20	..... hrs. ..... min.

9. Birthplace Peabody, Mass
(Town, county, and state)
10. Usual occupation U.S. Public Health, Asst.
11. Industry or business
FATHER 12. Name Chas. Stevens Tore
13. Birthplace Peabody, Mass
MOTHER 14. Maiden name Rose Belle Herbert
15. Birthplace Digby, Nova Scotia
16. Informant Miss Dorothy Tore
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1945 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Md.
18. Funeral director Wm Reuben Tumphrey
Address 1557 Wis. Ave. Bethesda, Md.
19. 7/24 (Date rec'd by registrar) 19 45 Wm E. Gibbs Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 5 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 1945 to July 21 1945 and that I last saw him alive on July 19 1945

Immediate cause of death	DURATION
Angina Pectoris	
Due to "Worry"	
Due to Peptic Ulcer	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. A. A. Dunn M. D.
Address Bethesda Md. Date signed 7-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07146

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery County
City or town: Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months - 2 days.
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hosp.
How long in hospital or institution? 10 months - 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4601 - 17th St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Ella Laurie Townsend

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Mr. Thomas Jincoln Townsend Deceased. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9, 1865

8. AGE: Years	Months	Days	If less than one day
80	2	16	hrs. min.

9. Birthplace: Philadelphia Pennsylvania (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own Home

FATHER
12. Name: John Miller.
13. Birthplace: Chester. Penna.

MOTHER
14. Maiden name: Sarah Jefferies.
15. Birthplace: Philadelphia, Pa.

16. Informant: Wash. San. & Hosp. Takoma Pk. Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-25-45 (month) (day) (year)
Cemetery or crematory: Washington
Location: D.C.
18. Funeral director: Jas. Saulsbury Sons
Address: 709-6 Pa Ave N.W.

19. July 25 1945 (Date rec'd by registrar) J. A. Saulsbury Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-25 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-15 1945, to 7-25 1945 and that I last saw h. alive on 7-25 1945.

	DURATION
Immediate cause of death: Cardiac Failure.	2 3/4 hrs.
Due to: Fibrous Pericarditis	2 yrs ±
Due to: Tuberculous Pulmonary Fibrosis	10 yrs ±
Other conditions: Dementia, Malnutrition, Genl' arteriosclerosis, hiprna	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. L. Kobb M.D. M. D. or other
Address: TAKOMA PARK, MD. Date signed: 7/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2) †

CERTIFICATE OF DEATH

★ 107147

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2700 "Q" Street N. W. Apt 130
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Virgil Harold TRAXLER, Lt(DC)USN Retired Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Donna Traxler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5 1896

8. AGE:	Years	Months	Days	If less than one day
	49	0	1	hrs. min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: William Traxler
13. Birthplace: New York

MOTHER
14. Maiden name: Melinda Berry
15. Birthplace: Pennsylvania

16. Informant: Wife: Mrs. Donna Traxler
Address: 2700 "Q" Street N. W., Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 July 1945 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Lee Funeral Home, Wm Lee Sm e.
Address: 4th & Massachusetts Ave, N.W., Wash. D.C.

19. July 9 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 July 1945 at 0940a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 7-6 1945 and that I last saw h.i.m. alive on 7-6 1945

	DURATION
Immediate cause of death: Hemorrhage from lung	1 da
Due to: Carcinoma of esophagus	1 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of esophagus Date of op. 7/5/45

Autopsy results: carcinoma esophagus with fistula to trachea

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eilif C Hanssen cdr(MC) USNR
M. D. or other

Address: U.S.N.H. Bethesda, Md Date signed 7/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

017148

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Monty

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5527 Dale Dr. apt. 10

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Peter Howe Voyn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 28 1945

8. AGE: Years | Months | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Arend Voyn

FATHER 13. Birthplace Mich.

MOTHER 14. Maiden name Edith Johnston

MOTHER 15. Birthplace Del.

16. Informant Arend Voyn

Address 5527 Dale Dr. Silver Spring md

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 25 1945 (month) (day) (year)

Cemetery or crematory Riverview Funeral Home

Location Glen Haven, Mich

18. Funeral director S. H. Hines Co.

Address 2901-14th St. N.W. Wash. D.C.

19. July 24 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 1:45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Congental heart disease	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bronhart M.D.

Sept. Med. Exam. M. D. or other

Address Gaithersburg md Date signed 7-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~18 days~~ 18 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Chancellor
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MABBLE, Frederick (n), CBM USN Ret. Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Caroline Louise Mabble

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10 Dec. 1886

8. AGE: Years	Months	Days	If less than one day
58	7	11	hrs. min.

9. Birthplace: Mich.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER 12. Name: Alfred R. Mabble

13. Birthplace: N.Y. (deceased)

MOTHER 14. Maiden name: Mary Malder

15. Birthplace: Germany (deceased)

16. Informant: Wife: Mrs. Caroline L. Mabble

Address: Chancellor, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-45 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Geo. W. Wise, J.C.F.

Address: 2900 M Street, N.W. Wash. D.C.

19. 7-21-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 July 1945, at 7:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 July 1945, to 21 July 1945 and that I last saw him alive on 21 July 1945

Immediate cause of death	DURATION
Hemorrhage, Subarachnoid (Non-traumatic)	1 week
Due to: Rupture of Aneurysm of Circle of Willis	4 months
Due to:	
Other conditions: ARTERIAL Hypertension	unknown
CEREBRAL ARTERIOSCLEROSIS	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: No operation

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clarence V. Vicars Lt Cmdr, MC USNR
M. D. or other

Address: US Naval Hospital, Bethesda, Md. Date signed 21 July 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-d) K

07150

CERTIFICATE OF DEATH ★

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 months 7 days
Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 13 months 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County:
City or town: Staten Island
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 Central Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: √

3.(a) FULL NAME: Gerard St. George WALKER, Lt. USNRRet. Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Divorced

6.(b) Name of husband or wife: Virginia R. Walker
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 8, 1902

8. AGE: Years	Months	Days	If less than one day
43	5	27	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Randolf Walker
13. Birthplace: Bermuda

MOTHER
14. Maiden name: Helena Jansen
15. Birthplace: New York

16. Informant: Sister: Miss Helena Walker
Address: 33 Central Avenue, Staten Is. N.Y.

17. Burial (Burial, cremation, or removal. Where?) Date thereof 9 July 1945 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: George W. Wise, Co. Inc. 117
Address: 2900 M Street N.W., Washington, D.C.

19. 6 July 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 July 1945 at 1155p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-31 1944 to 7-5 1945 and that I last saw h a.m. alive on 7-5 1945

	DURATION
Immediate cause of death: metastatic carcinoma	1 yr
Due to: Carcinoma rectum	2 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma rectum
Date of op. 6/26/44
Autopsy results: Carcinomatosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Emil C. Hansen CDR (MC) USNR
M. D. or other
Address: U.S.N.H. Bethesda, Md. Date signed 7/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

CERTIFICATE OF DEATH

67151

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery Suburban Hospt.

City or town Bethesda 4616 Drummond

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6/24/45 to 7/1/45

Hospital, institution, or street address where death occurred: Suburban Hospt. 8600 old Georgetown Rd.

How long in hospital or institution? 6/24/45 to 7/1/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4616 Drummond Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Julian C. Wallace

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Brenta Wallace

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	14	..... hrs. ..... min.

9. Birthplace Leesburg, Va. (Town, county, and state)

10. Usual occupation Retired Govt. Clerk

11. Industry or business

FATHER 12. Name ? Henry Clay Wallace

13. Birthplace ? Leesburg, Va

MOTHER 14. Maiden name ? Henrietta Forajthe

15. Birthplace Leesburg Va

16. Informant Mrs. Brenta F. Wallace

Address wife

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 7/2/45 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem-

Location Maryland

18. Funeral director Wm. Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda Md

19. 7/2 1945 Wm E Jolley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1945 to July 1, 1945 and that I last saw him alive on June 1, 1945.

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 mo.
Due to: Chr. arteriosclerosis	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Emil G. Bauersfeld M.D. M. D. or other

Address Bethesda, Md. Date signed 7/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

47152

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County Mont
City or town Tak. Pk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo
Hospital, institution, or street address where death occurred: Mabery Home 100 Baltimore
How long in hospital or institution? 6 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Washington County D.C.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 481 G. St. S.W. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida E. Weeks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace D.C.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Frank Payne
13. Birthplace Mass

MOTHER
14. Maiden name
15. Birthplace

16. Informant Mabery Home Resd.
Address 100 Baltimore Ave Tak. Pk.
17. Removal Date thereof July 10 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory D.C. Zoltanwell Funeral Home
Location 436 7th St. SW Wash. D.C.
18. Funeral director F. J. Zoltanwell
Address 436 7th St. SW. Wash. D.C.
19. 7/10/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to July 10 1945
and that I last saw h alive on July 9 1945
Immediate cause of death arteriosclerotic Heart disease — DURATION
Due to age
Due to
Other conditions Fracture rt. hip
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 7/9/45
Where did injury occur? Takoma Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Convalescent home
Means of injury Slipped Injured at work?

23. SIGNATURE Harry S. Douglas M.D.
M. D. or other
Address 1623 Columbia Rd Date signed 7/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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